

PLEASE
DO NOT
STAPLE
IN THIS
AREA

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #) <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (VA File #) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY		7. INSURED'S ADDRESS (No., Street)	
STATE		CITY	
ZIP CODE		STATE	
TELEPHONE (Include Area Code) ()		ZIP CODE	
TELEPHONE (INCLUDE AREA CODE) ()		11. INSURED'S POLICY GROUP OR FECA NUMBER	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="checkbox"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____			
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____			

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY		ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY															
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		17a. I.D. NUMBER OF REFERRING PHYSICIAN		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO															
19. RESERVED FOR LOCAL USE		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.		23. PRIOR AUTHORIZATION NUMBER															
1. _____		3. _____		2. _____		4. _____															
24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY		B Place of Service		C Type of Service		D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPSCS MODIFIER		E DIAGNOSIS CODE		F \$ CHARGES		G DAYS OR UNITS		H EPSDT Family Plan		I EMG		J COB		K RESERVED FOR LOCAL USE	
1																					
2																					
3																					
4																					
5																					
6																					
25. FEDERAL TAX I.D. NUMBER		SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. BALANCE DUE \$									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)				32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)				33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #													
SIGNED _____				DATE _____				PIN# _____				GRP# _____									

PHYSICIAN OR SUPPLIER INFORMATION